

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2487

CERTIFICATE OF DEATH

Reg. Dist. No.

02426

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> <i>md.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parsonskury</i> c. LENGTH OF STAY IN 1b <i>Life</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Funeral</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Wicomico</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parsonskury md</i> d. STREET ADDRESS <i>Funeral</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Ired</i> First <i>A</i> Middle <i>Armstrong</i> Last 4. DATE OF DEATH Month <i>2</i> Day <i>15</i> Year <i>1959</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-4-87</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>laborer</i>	11. BIRTHPLACE (State or foreign country) <i>Parsonskury</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>Benj Armstrong</i>	
14. MOTHER'S MAIDEN NAME <i>George Armstrong</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <i>280-10-9542</i>		17. INFORMANT <i>George Armstrong</i> Address <i>177X</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Prostate</i> DUE TO <i>177X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>3 months</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>15 Nov</i> , 19 <i>58</i> to <i>15 Feb</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>15 Feb</i> , 19 <i>59</i> , and that death occurred at <i>M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Furnell</i>		ADDRESS (Street, city or town, state) <i>652 W Main St, Salisbury, Md.</i>	
PHYSICIAN'S NAME (Type) <i>E. A. Furnell, M.D.</i>		DATE SIGNED <i>17 Feb 59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Blue Bell Cem</i>	22d. LOCATION (City, town, or county) (State) <i>Parsonskury md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Booker H. Love</i> ADDRESS		24a. REC'D BY REGISTRAR <i>25 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2436

CERTIFICATE OF DEATH

02427

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 803 Federal St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 803 Federal St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EULA Middle VERNA Last BELVIN		4. DATE OF DEATH Month FEB. Day 17th Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. <u>MARRIED</u> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1886
9. AGE (In years lost birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Goldsboro N. Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David H. Williams		14. MOTHER'S MAIDEN NAME Sallie Stone	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. INFORMANT Arthur C. Belvin (Husband) 803 Federal St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Convulsions 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Convulsion of bow DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH within 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-22 , 19 57 , to 2-17 , 19 59 , that I last saw the deceased alive on 2-17 , 19 59 , and that death occurred at 3:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 407 Camden Ave. Salisbury, Maryland DATE SIGNED Feb. 17 / 1959			
ACTUAL SIGNATURE Earl L. Royer		M.D. _____	
PHYSICIAN'S NAME (Type) Dr. Earl L. Royer		407 Camden Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 19, 1959	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. RECEIVED BY REGISTRAR FEB 24 59		DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Harte			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2437

CERTIFICATE OF DEATH

02428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 67 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Louis Middle Hick Last Bennett				4. DATE OF DEATH Month February Day 9 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 9, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Hebron, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas W. Bennett				14. MOTHER'S MAIDEN NAME Mary Ellen Phillips			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. 212-10-2670		17. INFORMANT Hospital Records, Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial insufficiency and posterior infarction DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 6 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis and emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec. 4 , 19 57 , to Feb. 9 , 19 59 , that I last saw the deceased alive on Feb. 9 , 19 59 , and that death occurred at 1:20 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 2/9/59							
ACTUAL SIGNATURE G. Kosmahly				M.D. Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-12-59		22c. NAME OF CEMETERY OR CREMATORY Hebron		22d. LOCATION (City, town, or county) (State) Hebron, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. S. Marvel Co - Salmar, Del.				ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1917

FILE NO.

DATE OF DEATH

SEX

AGE

PLACE OF BIRTH

DATE OF BIRTH

CONFIDENTIAL
B-10-10-10

CAUSE OF DEATH

1. (Immediate Cause)

2. (Underlying Cause)

2. (Underlying Cause)

3. (Contributing Cause)

3. (Contributing Cause)

4. (Manner of Death)

4. (Manner of Death)

5. (Occupation)

5. (Occupation)

6. (Habitual Residence)

6. (Habitual Residence)

7. (Usual Residence)

7. (Usual Residence)

8. (Place of Death)

8. (Place of Death)

9. (Date of Death)

9. (Date of Death)

10. (Time of Death)

10. (Time of Death)

11. (Signature of Registrar)

11. (Signature of Registrar)

12. (Signature of Physician)

12. (Signature of Physician)

13. (Signature of Coroner)

13. (Signature of Coroner)

14. (Signature of Burial Officer)

14. (Signature of Burial Officer)

15. (Signature of Witness)

15. (Signature of Witness)

16. (Signature of Registrar)

16. (Signature of Registrar)

17. (Signature of Physician)

17. (Signature of Physician)

18. (Signature of Coroner)

18. (Signature of Coroner)

19. (Signature of Burial Officer)

19. (Signature of Burial Officer)

20. (Signature of Witness)

20. (Signature of Witness)

21. (Signature of Registrar)

21. (Signature of Registrar)

22. (Signature of Physician)

22. (Signature of Physician)

23. (Signature of Coroner)

23. (Signature of Coroner)

24. (Signature of Burial Officer)

24. (Signature of Burial Officer)

25. (Signature of Witness)

25. (Signature of Witness)

26. (Signature of Registrar)

26. (Signature of Registrar)

27. (Signature of Physician)

27. (Signature of Physician)

28. (Signature of Coroner)

28. (Signature of Coroner)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2438

CERTIFICATE OF DEATH

Reg. Dist. No.

02429

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 5 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle TALBOT Last BOUNDS		4. DATE OF DEATH Month 2 Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1906
9. AGE (In years last birthday) 52		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co. Road Department		10b. KIND OF BUSINESS OR INDUSTRY Roads	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Wm. Bounds		14. MOTHER'S MAIDEN NAME Belle Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. G.T. Bounds, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 581.0 DUE TO Circulation of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Circulation of liver DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-13 , 19 58 to 2-4 , 19 59 , that I last saw the deceased alive on 2-4 , 19 59 , and that death occurred at 6:37 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE H. L. Reeves		M.D. Medical Center - Salisbury, Md	
PHYSICIAN'S NAME (Type) H.L. Reeves		DATE SIGNED Medical Center	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/8/59	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Pk.		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co, Salisbury, Maryland.		24a. REC'D BY REGISTRAR DATE FEB 10 59	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

Norman D. Baker

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BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2439

CERTIFICATE OF DEATH

Reg. Dist. No.

02430

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>DORCHESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GALES TO WIN 09X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DOROTHY REED BRADY</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 21 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 12 1910</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>KANSAS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALFRED REED</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>121-18-3925</u>	
17. INFORMANT <u>Walter Brady - Johnston Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u>5 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>016x Renal tuberculosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>57</u> , to <u>February 21</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>February 21</u> , 19 <u>59</u> , and that death occurred at <u>2:10 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Raymond M. Goss</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>2/23/59</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Maryland</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Marnel - Salisbury, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>FEB 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>5 hours</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGIE BELLE Brittingham</u>		4. DATE OF DEATH Month Day Year <u>February 7 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>	11. BIRTHPLACE (State or foreign country) <u>Woreester Co. Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Purnell J. Dennis</u>	
14. MOTHER'S MAIDEN NAME <u>Alice</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>INFORMANT</u>		17. ADDRESS <u>Mr Vincent K. Brittingham (Son) Hammond St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>59</u> , to <u>2/7</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/7</u> , 19 <u>59</u> , and that death occurred at <u>105</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Feb. 9/1959</u>			
ACTUAL SIGNATURE <u>Dr. Earl Beardsley</u>		M.D. <u>Maryland Ave. Salisbury, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Earl Beardsley</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 10, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parsonsbury Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Parsonsbury, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>FEB 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

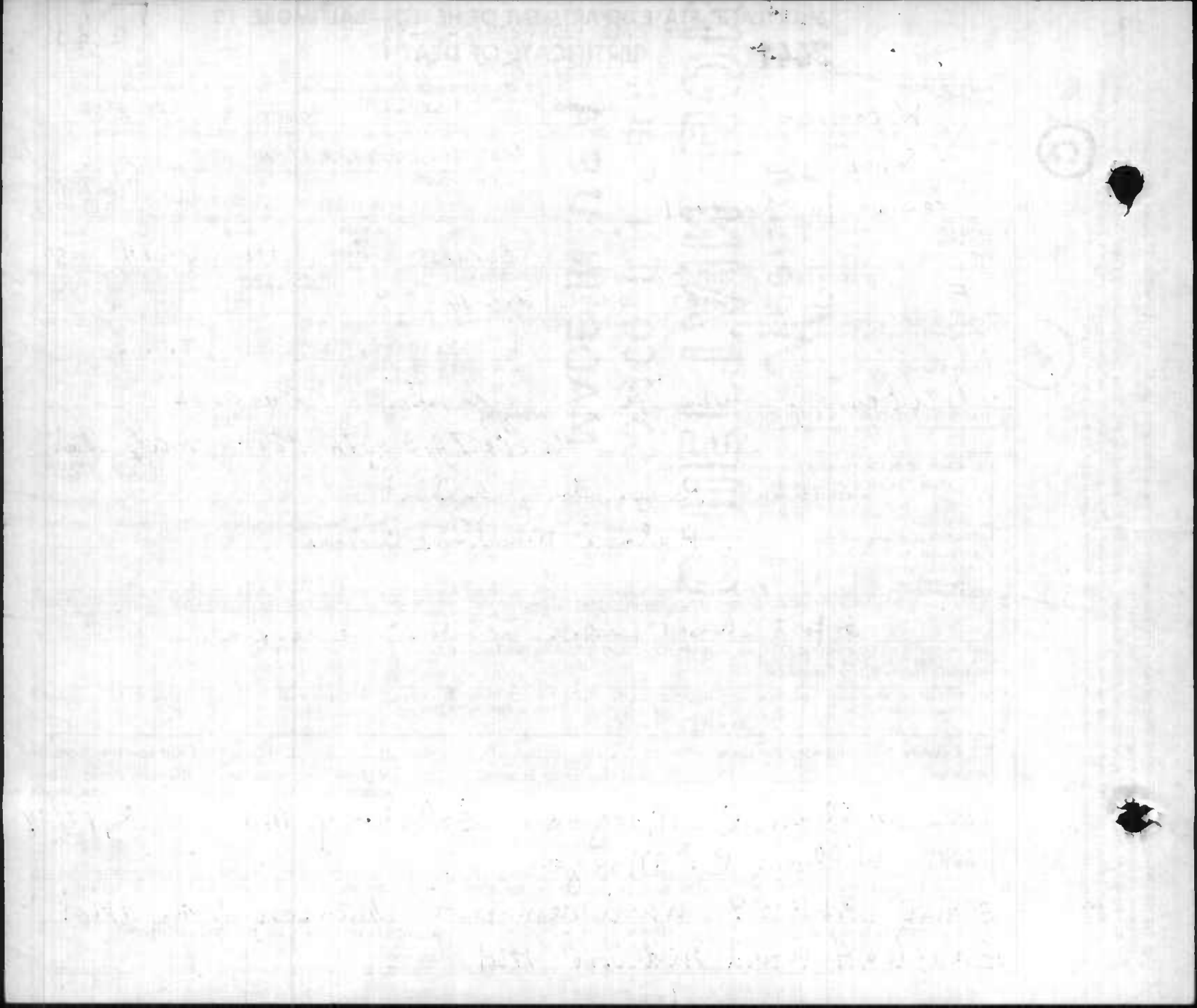
1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 2, 11 Film 6239 2-24-59 et
2441 Item 2 Film 6239 2-24-59 et
CERTIFICATE OF DEATH

02432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westover</u> <u>Pocomoke City</u> <u>18X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>Route # 1, Box 4-A</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Burgess</u>		4. DATE OF DEATH Month Day Year <u>February 14 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14-59</u>
9. AGE (In years last birthday) yrs. <u>4</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wilbert J Smyth</u>		14. MOTHER'S MAIDEN NAME <u>Christina Burgess</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Wilbert J. Smyth Pocomoke city Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hyaline Membrane disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>2/14/59</u>	
PHYSICIAN'S NAME (Type) <u>William C. Morgan</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Feb 16-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ward memorial</u>		22d. LOCATION (City, town, or county) (State) <u>marion som, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward</u> ADDRESS <u>marion md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2442

CERTIFICATE OF DEATH

Reg. Dist. No.

02433

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill Rural #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Riverside Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Annie</u> First <u>Chesser</u> Last		4. DATE OF DEATH <u>Feb</u> Month <u>3</u> Day <u>1959</u> Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29 - 1866</u>
9. AGE (In years last birthday) <u>92 1/2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>Corn Home</u>		12. CITIZEN OF WHAT COUNTRY? <u>Hallwood, Virginia</u>	
13. FATHER'S NAME <u>John Davis</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mae H. Chesser</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pyelitis</u> 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>600.0</u> DUE TO (c) <u>600.0</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>58</u> , to <u>7/3</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/3/59</u> , 19 <u>59</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L. P. Gramse</u>		ADDRESS (Street, city or town, state) <u>Salisbury, md</u>	
PHYSICIAN'S NAME (Type) <u>L. P. Gramse</u>		DATE SIGNED	
22. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Feb 3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Snow Hill, Rural #1 md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Gummis</u>		24a. REC'D BY REGISTRAR <u>FEB 6 59</u>	
ADDRESS <u>Snow Hill, md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2012

12-12-12

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
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52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
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70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

2443

CERTIFICATE OF DEATH

Reg. Dist. No.

02434

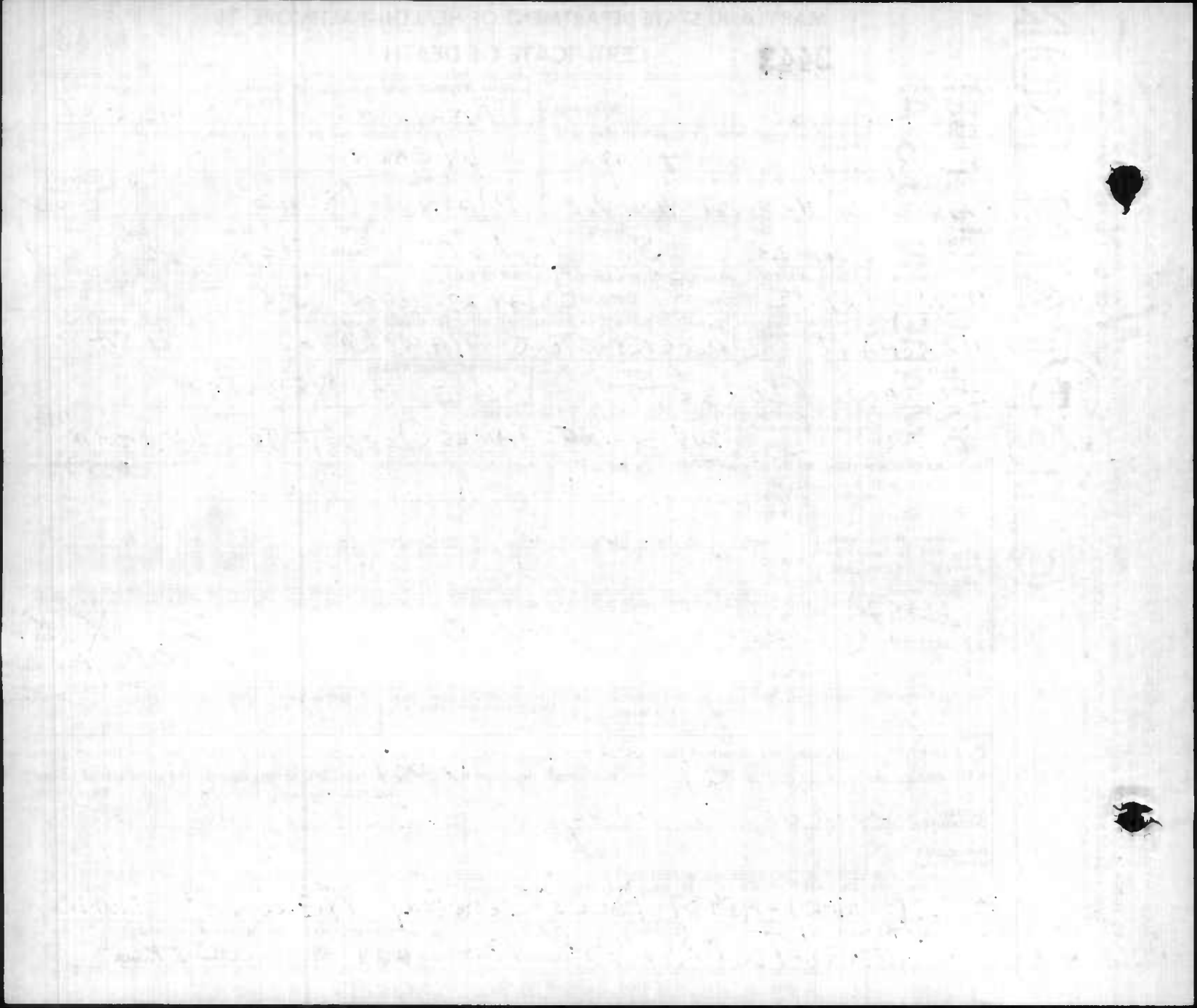
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>S.</u> Last <u>Corbett</u>		4. DATE OF DEATH Month <u>7</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 27 - 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	11. IF UNDER 24 HRS. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GROCERY STORE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD CORBETT</u>		14. MOTHER'S MAIDEN NAME <u>OLIVE B. WEBSTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-30-9204</u>	
17. INFORMANT <u>JAMES CORBETT JR.</u>		Address <u>WENONA MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Degenerative Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Pulmonary Fibrosis</u> DUE TO <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fibrinous Pericarditis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Had autopsy</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>2/22/59</u> , 19 <u>59</u> , to <u>2/26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-26</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>2-26-59</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MAR 1 - 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S CEMETERY</u>		22d. LOCATION (City, town, or county) <u>WENONA MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lowzhen Red Islander</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>MAR 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

MEDICAL CERTIFICATION

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

02435

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>5 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Whitesville 46 X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>M.</u> Last <u>Cordrey</u>		4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 8</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>SOLOMON E. TRUITT</u>		14. MOTHER'S MAIDEN NAME <u>ANNA M. WHITE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Chas. James - Millstone Del.</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of breast with</u> <u>170 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Metastases</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u> </u> , 19 <u> </u> , to <u>2-24</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-24</u> , 19 <u>59</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>2-24-59</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/27/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LINE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WHITESVILLE DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James - Millstone, Del.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

82

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VS A15 (4)
15M 9/58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2488

CERTIFICATE OF DEATH

02436

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Prince Georges</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> c. LENGTH OF STAY IN 1b <i>25 yrs</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Prince Georges</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i> d. STREET ADDRESS <i>1</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>May</i> Middle <i>Cornish</i> Last			4. DATE OF DEATH Month <i>Feb</i> Day <i>17</i> Year <i>1959</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-18-93</i>	9. AGE (In years last birthday) <i>65</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during mst of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Eden md</i>			
13. FATHER'S NAME <i>Julius Donahoe</i>			14. MOTHER'S MAIDEN NAME <i>Annie Christopher</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>29-031764</i>		17. INFORMANT <i>Roxie Slonford</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized carcinoma</i> <i>174X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Carcinoma of uterus</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <i>6 yrs</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <i>11-11</i> , 19 <i>54</i> , to <i>2-17</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>2-17</i> , 19 <i>59</i> , and that death occurred at <i>4:15</i> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Earl L. Royer</i>			ADDRESS (Street, city or town, state) <i>407 Garden St</i> DATE SIGNED <i>2-19-59</i>				
PHYSICIAN'S NAME (Type) <i>Earl L. Royer</i>			<i>Religious</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2-23-59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Flower Hill Cem</i>			
22d. LOCATION (City, town, or county) <i>Eden</i>		(State) <i>md</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles M. West</i> ADDRESS <i>Sabersburg md</i>			24a. REC'D BY REGISTRAR <i>Feb 25 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur E. Thomas</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G239 3-13-59 et

CERTIFICATE OF DEATH

02437

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1Yr. 4Mo. 10Da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>----</u> Last <u>Cottman</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>	
11. BIRTHPLACE (State or foreign country) <u>(Somerset) Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unk.</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Hospital Records -- Salisbury, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, Recurrent</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>?</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 D.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 21</u> , 19 <u>57</u> , to <u>Feb. 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 28</u> , 19 <u>59</u> , and that death occurred at <u>12:25 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. V. Juerman</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>	
PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>		DATE SIGNED <u>2/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Mar 4 1959 Wesley</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Marion Socy, Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H Ward</u>		ADDRESS <u>Marion Md</u>	
24a. REC'D BY REGISTRAR <u>Mar 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

02438

2446

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>123 Wakston Ave</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>Salisbury</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary</u> <u>Covington</u>				4. DATE OF DEATH Month Day Year <u>February</u> <u>1</u> <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/2/1884</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>1</u> <u>29</u>		IF UNDER 24 HRS. Hours Min. <u>1</u> <u>29</u>			
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert D. Willing</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Heath</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs William B. Hopkins, Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential hypertension</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1/15</u> , 19 <u>59</u> , to <u>2/1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>1/31</u> , 19 <u>59</u> , and that death occurred at <u>Salisbury, Md</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Earl M. Beardsley</u>				DATE SIGNED <u>Salisbury, Md 2/1/59</u>			
PHYSICIAN'S NAME (Type) <u>Earl M. Beardsley</u>				ADDRESS <u>Salisbury, Md. 2/1/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Paxson's Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.G. Messick, Blueview, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

FILE NO.

DATE

TIME OF DAY

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

TIME OF BIRTH

SEX

RACE

AGE

EDUCATION

RELIGION

OCCUPATION

STATUS

DECEASED BY

DECEASED BY

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2447

CERTIFICATE OF DEATH

02440

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 407 S. Division Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edna Middle Rebecca Last Culver		4. DATE OF DEATH Month February Day 26 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1903
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY Florist	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. Robley Livingston		14. MOTHER'S MAIDEN NAME Anna Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-10-3619	
17. INFORMANT Horace Culver		Address 407 S. Division Street Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac, Myocardial Insufficiency DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/10 19 58 , to 2/26 19 59 , that I last saw the deceased alive on 2-27 19 59 , and that death occurred at 7:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W. C. B. Smith		M.D. Med Center, Shy Md. DATE SIGNED 2/27/59	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, or other disposition Burial		22b. DATE THEREOF 3/1/1959	
22c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		22d. LOCATION (City, town, or county) (State) Delmar, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Wallace Salisbury, Md.		24a. REC'D BY REGISTRAR DATE MAR 2 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

See Div. 104

Form with multiple lines for text entry, including fields for name, date, and location. The text is mirrored and difficult to read.



2448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville 23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital.</u>		d. STREET ADDRESS _____	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LAWRENCE (LARRY) DAVIS</u>		4. DATE OF DEATH Month Day Year <u>February 22, 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15 1873</u>
9. AGE (In years last birthday) yrs. <u>85</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Gaffney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>Andrew Davis Whaleyville Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>With Intestinal Obstruction.</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 1, 1959</u> , to <u>Feb 22, 1959</u> , that I last saw the deceased alive on <u>Feb 22, 1959</u> , and that death occurred at <u>2:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Paul G. Cayaves</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>222 N. Division Street - 2/22/59</u>	
PHYSICIAN'S NAME (Type) <u>PAUL G. CAYAVES</u>		<u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Salisbury</u>	22d. LOCATION (City, town, or county) (State) <u>Whaleyville Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eller Whaley Salisbury Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2128

WILLIAM (last)

of the County of

State of

deceased

born at

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cause of death

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by

at

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2449

CERTIFICATE OF DEATH

02442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>RFD</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>ROBERT</u> Last <u>Downey</u>				4. DATE OF DEATH February 1 1959			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 10, 1909</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMMERCIAL FISHERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN, MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.P.</u>							
13. FATHER'S NAME <u>-</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE DOWNEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>NO</u>			
17. INFORMANT Address <u>Mrs. FRANCES DIETRICH, Ocean City MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2-1</u> , 19 <u>59</u> , to <u>2-1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-1</u> , 19 <u>59</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>William R. Ellis</u> M.D. <u>J. Lee Ellis, MD</u> <u>2-1-59</u> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

INVESTED STATE DEPARTMENT OF HEALTH—BUREAU OF VITALS

2428

Meenah

STAIR BOND

AGE IN YEARS

SEX

DATE OF BIRTH

BATLON

RESIDENTIAL

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2489

CERTIFICATE OF DEATH

Reg. Dist. No.

02443

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg c. LENGTH OF STAY IN 1b Parsonsborg d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg d. STREET ADDRESS In Village e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle LAVENIA Last DRISCOLL				4. DATE OF DEATH Month FEBRUARY Day 17th Year 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 9, 1883	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0 Days 8		11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home				10b. KIND OF BUSINESS OR INDUSTRY Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME David S. Shockley				14. MOTHER'S MAIDEN NAME Amelia Ellen Bowen			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. INFORMANT Miss. Edith B. Shockley (Sister) Parsonsborg, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 444 X Hypertension & cardiac failure DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) 						INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) massive nodular goiter blood.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Delmar (County) Delaware (State) 							
21. I certify that I attended the deceased from 9/6 , 19 59 to death , 19 , that I last saw the deceased alive on 2/14 , 19 59 , and that death occurred at 6:20 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Ernest M. Larmore M.D.				DATE SIGNED Feb. 17 / 1959			
PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore				Grove St. Delmar, Delaware			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 19, 1959		22c. NAME OF CEMETERY OR CREMATORY Parsonsborg Cemetery		22d. LOCATION (City, town, or county) Parsonsborg, Maryland (State) 	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND				24a. REC'D BY REGISTRAR FEB 19 '59		24b. REGISTRAR'S SIGNATURE Arthur J. Mears	

CENTRAL OFFICE

2180

Location

Address

Phone

Barrenburg

Barrenburg

In Village

In Village

RECEIVED 1957

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BARRENBURG

BARRENBURG

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2450

CERTIFICATE OF DEATH

Reg. Dist. No.

02444

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 731 E.Church St		d. STREET ADDRESS 731 E.Church St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle E. Last FARLOW		4. DATE OF DEATH Month FEBRUARY Day 18th Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 11, 1886
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk of Court -Wico.Co.Court House		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John W. Farlow		14. MOTHER'S MAIDEN NAME Lucy Ellen Leonard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. John C. Walston (Nephew) R.D.# (Mt. Hermon Road) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rt. Breast 170 x DUE TO (b) with metastases. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November, 1958 to Feb. 18, 1959 , that I last saw the deceased alive on Feb. 18, 1959 , and that death occurred at 11:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pine Bluff Rd. Salisbury, Maryland DATE SIGNED Feb. 20 / 1959			
ACTUAL SIGNATURE Thomas C. Hill, Jr. M.D.		22. LOCATION (City, town, or county) (State)	
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill		22b. DATE THEREOF Feb. 21, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		23b. REGISTRAR'S SIGNATURE Feb 24 '59	
ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR FEB 24 '59	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1, Film G239, 3/10/59 fcy

2451

CERTIFICATE OF DEATH

02445

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Done Fitzgerald		4. DATE OF DEATH Feb. 21, 1959		5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1876		9. AGE (In years lost birthday) 82 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dr. William Stewart		14. MOTHER'S MAIDEN NAME Henrietta Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mr. Thomas H. Fitzgerald		Address 63 Radnor Ave Naugatuck, Conn.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Complete Heart Block DUE TO (c) Hypertensive Cardio-Vas. Disease						INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 weeks 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20 Princeton St. Princeton		20f. City or town (County) (State)	
21. I certify that I attended the deceased from June 1955 to Feb 1959 , that I last saw the deceased alive on Feb. 21, 1959 , and that death occurred at 10:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE B. Frank Gigante		M.D.		ADDRESS (Street, city or town, state) 20 Princeton St. Princeton		DATE SIGNED 2/22/59	
PHYSICIAN'S NAME (Type) B. FRANK GIGANTE							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 2-24-59		22c. NAME OF CEMETERY OR CREMATORY Manokin Presbyterian		22d. LOCATION (City, town, or county) (State) Princess Anne, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Levin P. Wilson		ADDRESS Princess Anne, Md.		24a. REC'D BY REGISTRAR FEB 26 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

2021

<p>1. Name of the deceased: <u>Mr. S. S. Srinivas</u></p>		<p>2. Age: <u>45</u></p>		<p>3. Sex: <u>Male</u></p>	
<p>4. Date of birth: <u>15/10/1976</u></p>		<p>5. Place of birth: <u>Bangalore</u></p>		<p>6. Nationality: <u>Indian</u></p>	
<p>7. Date of death: <u>10/11/2021</u></p>		<p>8. Time of death: <u>10:30 AM</u></p>		<p>9. Cause of death: <u>COVID-19</u></p>	
<p>10. Place of death: <u>Home</u></p>		<p>11. Name of the attending physician: <u>Dr. S. S. Srinivas</u></p>		<p>12. Signature of the attending physician: <u>[Signature]</u></p>	
<p>13. Name of the informant: <u>Mr. S. S. Srinivas</u></p>		<p>14. Address of the informant: <u>10, 1st Cross, 1st Stage, Bangalore</u></p>		<p>15. Signature of the informant: <u>[Signature]</u></p>	
<p>16. Name of the medical officer: <u>Dr. S. S. Srinivas</u></p>		<p>17. Address of the medical officer: <u>10, 1st Cross, 1st Stage, Bangalore</u></p>		<p>18. Signature of the medical officer: <u>[Signature]</u></p>	
<p>19. Name of the registrar: <u>Mr. S. S. Srinivas</u></p>		<p>20. Address of the registrar: <u>10, 1st Cross, 1st Stage, Bangalore</u></p>		<p>21. Signature of the registrar: <u>[Signature]</u></p>	

INDIAN STATE DEPARTMENT OF HEALTH - BANGALORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2452

CERTIFICATE OF DEATH

Reg. Dist. No.

02446

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4yrs. 9mos. 21d.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Taneytown 06x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 340 E. Baltimore Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lumie Middle Grace Last Fleagle				4. DATE OF DEATH Month Feb. Day 6 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 13, 1871	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 87 Days 87 Hours 87 Min. 87		IF UNDER 24 HRS. Months 87 Days 87 Hours 87 Min. 87			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.				10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Taneytown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Randolph Martin				14. MOTHER'S MAIDEN NAME Henaetti Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk. (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records - Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis general. DUE TO (c) ?							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ?							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury, Maryland	
21. I certify that I attended the deceased from April 15, 1954 to Feb. 6, 1959 , that I last saw the deceased alive on Feb. 6, 1959 , and that death occurred at 10:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 2/7/59							
ACTUAL SIGNATURE Dr. V. Juerman				M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) Verner Juerman, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10, 1959		22c. NAME OF CEMETERY OR CREMATORY Baust Church Cemetery		22d. LOCATION (City, town, or county) (State) Tyrone, Carroll, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C.O. Fuss & Son				ADDRESS Taneytown, Maryland		24a. REC'D BY REGISTRAR DATE FEB 10 '59	
						24b. REGISTRAR'S SIGNATURE Arthur E. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2453

CERTIFICATE OF DEATH

02447

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN TB 183 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Clarence Middle Hanley Last Foreman			4. DATE OF DEATH Month February Day 24 Year 19 59				
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1905		9. AGE (In years last birthday) 53 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Foreman, Sr.				14. MOTHER'S MAIDEN NAME Julia Leonard			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Hospital Records, Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 5 min.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pemphigus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug. 25 , 19 58 , to Feb. 24 , 19 59 , that I last saw the deceased alive on Feb. 24 , 19 59 , and that death occurred at 3:30P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman				ADDRESS (Street, city or town, state) Deer's Head State Hospital		DATE SIGNED 2/24/59	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-28-59	22c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		22d. LOCATION (City, town, or county) (State) Nr. Newark, Md			
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart				ADDRESS Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR DATE MAR 2 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Huns

CERTIFICATE OF DEATH

1913

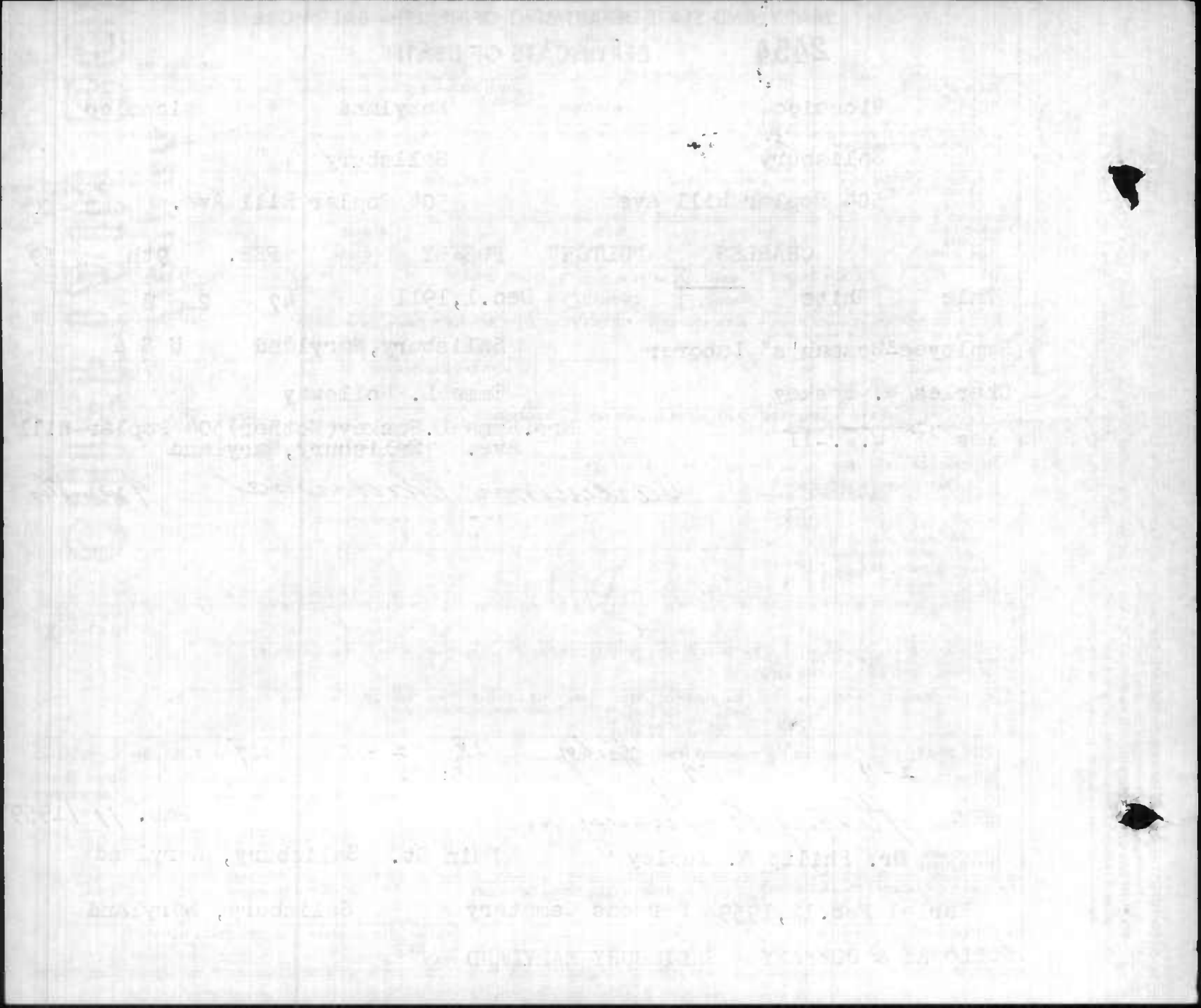
MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible.

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 2454
 CERTIFICATE OF DEATH

02448
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 504 Poplar Hill Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle FULTON Last FOSKEY		4. DATE OF DEATH Month FEB. Day 9th Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1911
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR 2 Months 8 Days 8 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee "Bozman's"		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Charles W. Foskey		14. MOTHER'S MAIDEN NAME Emma L. Holloway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.-II	
17. INFORMANT Mrs. Emma L. Foskey (Mother)		Address 504 Poplar Hill Ave., Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X Carcinoma Pancreas DUE TO (b) 7 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 48 , to 2-9 , 19 59 , that I last saw the deceased alive on 2-7 , 19 59 , and that death occurred at 5:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main St. Salisbury, Maryland DATE SIGNED Feb. 11 / 1959			
ACTUAL SIGNATURE Philip A. Insley M.D.		PHYSICIAN'S NAME (Type) Dr. Philip A. Insley	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 12, 1959	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR FEB 13 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2455

CERTIFICATE OF DEATH

Reg. Dist. No.

02449

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Polk Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>19x-2</u>	
3. NAME OF DECEASED (Type or print) First <u>ANTHONY</u> Middle <u>Gale</u> Last <u>Gale</u>		4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/1903</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAW MILL</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>WILLIAM GALE</u>		14. MOTHER'S MAIDEN NAME <u>LEARH ANN. JONES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> <u>NORMAN GALE PRINCESS ANNE, MARYLAND</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x</u> DUE TO <u>Premia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Accident</u> DUE TO <u>arterio sclerosis</u> (c) <u>arterio sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-29</u> , 19 <u>57</u> , to <u>2-17</u> , 19 <u>59</u> that I last saw the deceased alive on <u>2-17</u> , 19 <u>59</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. J. B. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Med. Center, Hyattsville, Md.</u> DATE SIGNED <u>3/1/59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT ZION</u>	22d. LOCATION (City, town, or county) (State) <u>POLK ROAD MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM H. JAMES JR.</u>		ADDRESS <u>PRINCESS ANNE, MARYLAND</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>G. L. K. K.</u>	

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
CENTRAL OFFICE

1965

OFFICE OF THE ASSISTANT SECRETARY
FOR PUBLIC HEALTH AND SAFETY

WASHINGTON, D.C. 20462

Memorandum for the Assistant Secretary
for Public Health and Safety

Subject: [Illegible]
Reference: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2456

CERTIFICATE OF DEATH

02450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen. Gen. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CECIL Middle C. Last HILL		4. DATE OF DEATH Month FEB. Day 2nd Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1886
9. AGE (In years last birthday) 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant (Grocery Store)	11. BIRTHPLACE (State or foreign country) Middletown, New York
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Neal Hill	
14. MOTHER'S MAIDEN NAME (Unk)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-32-7540		17. INFORMANT Mrs. Millie May Hill (Wife) Address 736 S. Division Street - Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anterior electric conduction system DUE TO (c) yes		INTERVAL BETWEEN ONSET AND DEATH yes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ischemic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-3 , 19 55 , to 2-2 , 19 59 , that I last saw the deceased alive on 2-2 , 19 59 , and that death occurred at 4:53 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Feb. 4 / 1959	
ACTUAL SIGNATURE Earl L. Royer M.D.		PHYSICIAN'S NAME (Type) Dr. Earl L. Royer	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 5, 1959	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		24a. REC'D BY REGISTRAR FEB 5 '59	
ADDRESS SALISBURY MARYLAND		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2457

CERTIFICATE OF DEATH

Reg. Dist. No. 02451

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Holbrook Last Holbrook		4. DATE OF DEATH Month February Day 27 Year 1959	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 25, 1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Johnson		14. MOTHER'S MAIDEN NAME Katie Long	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral hemorrhage 443x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from February 2, 1959 , to February 27, 1959 , that I last saw the deceased alive on February 27, 1959 , and that death occurred at 2:30P M , from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. V. Juerman		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 2/27/59	
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/8/59	22c. NAME OF CEMETERY OR CREMATORY GRACE	22d. LOCATION (City, town, or county) (State) VENTON MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE WILLIAM H. JAMES JR. PRINCESS ANNE, MD		24a. REC'D BY REGISTRAR DATE MAR 6 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in b, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

02452

2490

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve				c. LENGTH OF STAY IN 1b 3 mo.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bivalve				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EVA Middle HORSEMAN Last				4. DATE OF DEATH Month Feb. Day 15 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/27/84	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 9 Days 18 Hours 18 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.							
13. FATHER'S NAME Louis Horner				14. MOTHER'S MAIDEN NAME -----			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Floyd Horseman, Bivalve, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma of Lung 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Breast DUE TO (c) Unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 4 , 19 56 , to Feb. 15 , 19 59 , that I last saw the deceased alive on Feb 14 , 19 59 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED 2/17/59							
ACTUAL SIGNATURE David J. Schum M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/17/59		22c. NAME OF CEMETERY OR CREMATORY Tyaskin Cem.		22d. LOCATION (City, town, or county) (State) Tyaskin, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. H. Messersmith, Bivalve, Md.				24a. REC'D BY REGISTRAR DATE FEB 24 '59		24b. REGISTRAR'S SIGNATURE Cuthbert S. Frank	

TO HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				/d. STREET ADDRESS <u>MAIN + BAPTIST STREET</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eunice</u> Middle Last <u>Horsey</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Quantico, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ronald Horsey</u>				14. MOTHER'S MAIDEN NAME <u>Viola Horsey-Mardela, Md.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-05-7299</u>		INFORMANT Address <u>Viola Horsey-Mardela, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X Atelectasis of Both lower lobes of lungs.</u> DUE TO (b) <u>Paralytic Ileus - post-operative</u> DUE TO (c) <u>Adenocarcinoma of Rectum</u>							INTERVAL BETWEEN ONSET AND DEATH <u>48 Hrs.</u> <u>5 days</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>Feb. 16, 1959</u> to <u>Feb. 25, 1959</u> , that I last saw the deceased alive on <u>Feb. 25, 1959</u> , and that death occurred at <u>5:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul G. Cayaves</u> M.D.		ADDRESS (Street, city or town, state) <u>222 N. Division St. - 2-25-59.</u> DATE SIGNED					
PHYSICIAN'S NAME (Type) <u>PAUL G. CAYAVES</u>		<u>Salisbury, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Quantico Cern.</u>		22d. LOCATION (City, town, or county) (State) <u>Quantico Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker M. West</u> ADDRESS <u>Salisbury, Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

2508

Age 70

Sex M

Married

On the 10th day of March 1908 at the residence of the deceased, 1234 Main Street, City of New York, I, the undersigned, a duly qualified and licensed physician, do hereby certify that the above named person died of the following disease or diseases, to-wit: Heart Disease, and that the death was caused by the same.

Witness my hand and the seal of my office this 10th day of March 1908.

Dr. J. C. Jones
City of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2459

Item 2. See: Item # 17, et

CERTIFICATE OF DEATH

02454

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>23X-2</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <u>Showell</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>			d. STREET ADDRESS <u>---</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>TEENA</u> Middle <u>LOUISE</u> Last <u>Hudson</u>			4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 16, 1959</u>	9. AGE (In years last birthday) yrs. <u>3</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min. <u>3</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>SALISBURY MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>KENNARD HUDSON</u>			14. MOTHER'S MAIDEN NAME <u>LOUISE TOWNSEND</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		INFORMANT Address <u>Mr. KENNARD HUDSON, SHOWELL, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X Respiratory Failure</u> DUE TO (b) <u>Prematurity - Birth Weight 750 gms</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (c) <u>---</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>---</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>---</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>---</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>---</u>	
20f. (City or town) <u>---</u>		20g. (County) <u>---</u>		20h. (State) <u>---</u>	
21. I certify that I attended the deceased from <u>2/15</u> , 19 <u>59</u> , to <u>2/18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>59</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Medical Center Salisbury Md</u> DATE SIGNED <u>2/19/59</u>					
ACTUAL SIGNATURE <u>William C. Morgan</u> M.D.		PHYSICIAN'S NAME (Type) <u>---</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>	
22d. LOCATION (City, town, or county) <u>BISHOPVILLE MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Barbary Berlin Md</u>		ADDRESS <u>---</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>					

2082262XV0

CERTIFICATE OF DEATH



The deceased was born on

at

and died on

at

and was buried on

at

and was buried on

at

and was buried on

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2460

CERTIFICATE OF DEATH

02455

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George W. Jones</u>				4. DATE OF DEATH Month Day Year <u>February 11 1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/23/1862</u>	
9. AGE (In years last birthday) <u>96</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Henry Jones</u>				14. MOTHER'S MAIDEN NAME <u>Learh Leatherbury</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>NAME</u>		17. INFORMANT Address <u>Martha Goslee R.F.D.#1 Mardela Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of Right Foot</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic Heart Disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks 35+ yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 2, 1959</u> , to <u>Feb. 11, 1959</u> , that I last saw the deceased alive on <u>Feb. 11, 1959</u> , and that death occurred at <u>11:59</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul G. Cayaves</u> M.D.				ADDRESS (Street, city or town, state) <u>222 N. Division St.</u>			
PHYSICIAN'S NAME (Type) <u>PAUL G. CAYAVES</u>				DATE SIGNED <u>2-11-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/14/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sharptown</u>		22d. LOCATION (City, town, or county) (State) <u>Sharptown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton F. Stewart</u>				24a. REC'D BY REGISTRAR <u>Feb 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form 10-58

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of undertaker		14. Signature of cemetery		15. Signature of burial place		16. Signature of interment	
17. Signature of crematorium		18. Signature of cremation		19. Signature of cremation		20. Signature of cremation	
21. Signature of cremation		22. Signature of cremation		23. Signature of cremation		24. Signature of cremation	
25. Signature of cremation		26. Signature of cremation		27. Signature of cremation		28. Signature of cremation	
29. Signature of cremation		30. Signature of cremation		31. Signature of cremation		32. Signature of cremation	
33. Signature of cremation		34. Signature of cremation		35. Signature of cremation		36. Signature of cremation	
37. Signature of cremation		38. Signature of cremation		39. Signature of cremation		40. Signature of cremation	
41. Signature of cremation		42. Signature of cremation		43. Signature of cremation		44. Signature of cremation	
45. Signature of cremation		46. Signature of cremation		47. Signature of cremation		48. Signature of cremation	
49. Signature of cremation		50. Signature of cremation		51. Signature of cremation		52. Signature of cremation	
53. Signature of cremation		54. Signature of cremation		55. Signature of cremation		56. Signature of cremation	
57. Signature of cremation		58. Signature of cremation		59. Signature of cremation		60. Signature of cremation	
61. Signature of cremation		62. Signature of cremation		63. Signature of cremation		64. Signature of cremation	
65. Signature of cremation		66. Signature of cremation		67. Signature of cremation		68. Signature of cremation	
69. Signature of cremation		70. Signature of cremation		71. Signature of cremation		72. Signature of cremation	
73. Signature of cremation		74. Signature of cremation		75. Signature of cremation		76. Signature of cremation	
77. Signature of cremation		78. Signature of cremation		79. Signature of cremation		80. Signature of cremation	
81. Signature of cremation		82. Signature of cremation		83. Signature of cremation		84. Signature of cremation	
85. Signature of cremation		86. Signature of cremation		87. Signature of cremation		88. Signature of cremation	
89. Signature of cremation		90. Signature of cremation		91. Signature of cremation		92. Signature of cremation	
93. Signature of cremation		94. Signature of cremation		95. Signature of cremation		96. Signature of cremation	
97. Signature of cremation		98. Signature of cremation		99. Signature of cremation		100. Signature of cremation	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2461 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02456

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parksley</u> <u>83x-9</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Donald Justice Jr.</u>				4. DATE OF DEATH Month <u>2-</u> Day <u>4-</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 11, 1919</u>		9. AGE (In years last birthday) <u>39</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>DONALD JUSTICE SR.</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE JUSTICE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>DAVID JUSTICE</u> Address <u>SALISBURY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u></p> <p><u>910.8</u> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</p> </div> <div> <p>(b) <u>Hemorrhage from ruptured spleen</u></p> <p>(c) <u>Crushed chest-left: fractured left tibia and rib, avulsion of scalp: contused left kidney with hematuria: fracture of body of 4th lumbar vert.</u></p> </div> <div> <p>Interval between onset and death <u>Sudden</u></p> <p>Hours <u> </u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>left kidney with hematuria: fracture of body of 4th lumbar vert.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tree fell on him while helping to cut timber.</u>					
20c. TIME OF INJURY Month, Day, Year <u>3 P.M. 1-29-59</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u>		20f. (City or town) (County) (State) <u>Parksley Accomac Va.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-5-59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/8/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NELSON CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WORCESTER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry M. Johnson</u>				ADDRESS <u>Parksley, Va.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK
MEDICAL EXAMINER

DEPT. OF HEALTH
ALBANY

NAME OF DECEASED: _____
AGE: _____ SEX: _____
DATE OF DEATH: _____

PLACE OF DEATH: _____
CITY: _____ COUNTY: _____

RESIDENCE: _____
OCCUPATION: _____

CAUSE OF DEATH: _____
MANNER OF DEATH: _____

DATE OF EXAMINATION: _____
SIGNATURE OF EXAMINER: _____

DATE OF DEATH: _____
SIGNATURE OF DECEASED: _____

DATE OF EXAMINATION: _____
SIGNATURE OF EXAMINER: _____

DATE OF DEATH: _____
SIGNATURE OF DECEASED: _____

DATE OF EXAMINATION: _____
SIGNATURE OF EXAMINER: _____

DATE OF DEATH: _____
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SIGNATURE OF EXAMINER: _____

DATE OF DEATH: _____
SIGNATURE OF DECEASED: _____

DATE OF EXAMINATION: _____
SIGNATURE OF EXAMINER: _____

CERTIFICATE OF DEATH

Reg. Dist. No.

02457

2491

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 2, Salisbury		c. LENGTH OF STAY IN TB 7 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles W. B. Middle Lynch Last Lynch		4. DATE OF DEATH Month February Day 15 , Year 19 59.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-1893
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	IF UNDER 24 HRS. Months 65 Days 65 Hours 65 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
11. BIRTHPLACE (State or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Wash Lynch		14. MOTHER'S MAIDEN NAME Sarah Davis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT McCHARLES E. LYNCH		Address Ocean City Mo	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 331X DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 1, 1958 , to Feb. 15, 1959 , that I last saw the deceased alive on Feb. 14, 1959 , and that death occurred at 2:40 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip A. Insley M.D.		ADDRESS (Street, city or town, state) Salisbury, Md. DATE SIGNED 2-16-59	
PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		Main St., Salisbury, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/17/59	22c. NAME OF CEMETERY OR CREMATORY EVERGREEN	22d. LOCATION (City, town, or county) (State) BERLIN MD
23. FUNERAL DIRECTOR'S SIGNATURE Roma A. Burbage		ADDRESS Berlin Md	
24a. REC'D BY REGISTRAR FEB 18 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF BIRTH	
SEX		AGE	
RACE		RELIGION	
MARRIED		SINGLE	
EDUCATION		OCCUPATION	
PLACE OF BIRTH		DATE OF DEATH	
CAUSE OF DEATH		PLACE OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
DATE		TIME	
LOCATION		HOSPITAL	
PHYSICIAN		NURSE	
CORONER		JURY	
FAMILY		FRIENDS	
CITY		COUNTY	
STATE		COUNTRY	

1 **MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

2462

CERTIFICATE OF DEATH

Reg. Dist. No.

02458

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>INNSULA GENERAL Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EUGENE</u> Middle <u>P.</u> Last <u>MATTHEWS</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 25, 1887</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>	IF UNDER 24 HRS. Months <u>71</u> Days <u>71</u> Hours <u>71</u> Min. <u>71</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRODUCE BROKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CANNING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANCIS E. MATTHEWS</u>				14. MOTHER'S MAIDEN NAME <u>SARAH H. POWELL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-03-9153</u>		INFORMANT Address <u>MRS SADIE H. MATTHEWS, POCOMOKE CITY, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach & metastases</u> 151X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19__		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William H. Fisher Jr</u> M.D.				DATE SIGNED <u>2/25/59</u>			
PHYSICIAN'S NAME (Type) <u>WILLIAM H. FISHER JR</u>				<u>SALISBURY, MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-28-59</u>		22c. NAME OF CEMETERY <u>ST. MARY EPISCOPAL</u>		22d. LOCATION (City, town, or county) (State) <u>POCOMOKE CITY, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u> ADDRESS <u>POCOMOKE CITY, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

2463

CERTIFICATE OF DEATH

Reg. Dist. No.

02459

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Oliver Last McINTYRE		4. DATE OF DEATH Month FEBRUARY Day 20 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1888
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 8 Days 5 Hours 6 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Retired		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James McIntyre		14. MOTHER'S MAIDEN NAME Georgia Jones	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Insufficiency DUE TO (c) Arteriosclerotic Cardiovascular Dis.		INTERVAL BETWEEN ONSET AND DEATH 8 days 5 yrs 6+ yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/14 , 19 59 , to 2/20 , 19 59 that I last saw the deceased alive on 2/19 , 19 59 , and that death occurred at 2:15 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Rufus S. GARDNER JR.		ADDRESS (Street, city or town, state) Pinebluff Rd. Salisbury, Md.	
PHYSICIAN'S NAME (Type) Rufus S. GARDNER JR.		DATE SIGNED 2/20/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/22/59	
22c. NAME OF CEMETERY OR CREMATORY Grace Episcopal		22d. LOCATION (City, town, or county) (State) Mt. Vernon Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James Vernon Prince Anne Md.		24a. REC'D BY REGISTRAR DATE FEB 25 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneass			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
IN SENATE
January 10, 1901.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899.
ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS.
1901.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2464

CERTIFICATE OF DEATH

02460

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY Sussex ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Georgetown (Rural) 46x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula Gen. Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Elizabeth Mifflin				4. DATE OF DEATH Month Day Year 2 11 19 59			
5. SEX FM	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-1896		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles H. Waples				14. MOTHER'S MAIDEN NAME Catherine Mitchell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222 07 9876		17. INFORMANT Address Howard Stevenson, Dover, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA PANCREAS 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 9 MOS - APP
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Feb 2 19 59 to Feb 11 19 59 , that I last saw the deceased alive on Feb 11 19 59 , and that death occurred at 10 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED John M. Bloxam M.D. MEDICAL CENTER 2/13/59 PHYSICIAN'S NAME (Type) JOHN M. BLOXAM M.D. SALISBURY, MD							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/15/59		22c. NAME OF CEMETERY OR CREMATORY Baptist Cemetery		22d. LOCATION (City, town, or county) (State) Georgetown, Del.	
23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md.				24a. REG'D. BY REGISTRAR SEP 17 59		24b. REGISTRAR'S SIGNATURE Arthur S. Finner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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<p>1. Name of deceased</p>		<p>2. Sex</p>	
<p>3. Age</p>		<p>4. Date of birth</p>	
<p>5. Place of birth</p>		<p>6. Date of death</p>	
<p>7. Cause of death</p>		<p>8. Place of death</p>	
<p>9. Signature of physician</p>		<p>10. Signature of registrar</p>	
<p>11. Date of registration</p>		<p>12. Place of registration</p>	

CERTIFICATE OF DEATH

Reg. Dist. No.

02461

2465

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 90 Springhill Sanitarium, Inc.		d. STREET ADDRESS 1 Broad St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle R Last MILLER		4. DATE OF DEATH Month FEB. Day 27th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1889
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co-Owner & Operator		10b. KIND OF BUSINESS OR INDUSTRY Miller & Howie	
11. BIRTHPLACE (State or foreign country) Milford, New Jersey		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William H. Miller		14. MOTHER'S MAIDEN NAME Nellie Rapp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 214-10-7925	
17. INFORMANT Mrs. Beulah Hare (Friend)		Address 205 Marshall St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 1958 to Feb. 26, 1959 that I last saw the deceased alive on Feb. 26th 1959 , and that death occurred at 1:55 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury Md DATE SIGNED Feb. 27/1959			
ACTUAL SIGNATURE Dr. Wilber R. Ellis Jr.		M.D. Salisbury Md	
PHYSICIAN'S NAME (Type) Dr. David J. Gilmore		Medical Center- Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Mar. 2, 1959	Holland Presbyterian Cem.	Holland, New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

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TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

STATE OF TEXAS

1913

County of ...

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Handwritten signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02462

2466

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>3da.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DAGSBORO, Del. 46x-3</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CARRIE</u> Middle <u>MURRAY</u> Last <u>MURRAY</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Aug 14 1889</u> 9. AGE (In years last birthday) <u>69</u> yrs. 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> 11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LEVIN L. DERRICKSON</u> 14. MOTHER'S MAIDEN NAME <u>AMYLIE DERRICKSON</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <u>WOODROW MURRAY DAGSBORO, DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary Arteriosclerosis</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paroxysmal Atrial Fibrillation</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <u>2-22-1959</u> to <u>2-25-1959</u> that I last saw the deceased alive on <u>19</u> and that death occurred at <u>9:40</u> A. M. from the causes and on the date stated above. ACTUAL SIGNATURE <u>David J. Schum</u> ADDRESS (Street, city or town, state) <u>Salisbury Md.</u> DATE SIGNED <u>2/25/59</u> PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>2/28/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>St. Georges Cem.</u> 22d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE</u> <u>Del</u>		24a. REC'D BY REGISTRAR <u>Watson & Gray Frankford Del.</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> DATE <u>MAR 4 '59</u>	

CERTIFICATE OF DEATH

2248

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2467

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i> <i>23X-2</i> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>PENINSULA General HOSPITAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>RICHARD</i> Middle <i>CHARLES</i> Last <i>NELSON</i>		4. DATE OF DEATH Month <i>February</i> Day <i>2</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JANUARY 30, 1959</i>
9. AGE (In years last birthday) yrs. <i>2</i>		10. IF UNDER 1 YEAR Months <i>2</i> Days <i>2</i> Hours <i>2</i> Min. <i>2</i>	11. IF UNDER 24 HRS. Months <i>2</i> Days <i>2</i> Hours <i>2</i> Min. <i>2</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>SALISBURY MD</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>BENJAMIN W. NELSON</i>	
14. MOTHER'S MAIDEN NAME <i>Dorothy Johnson</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>MR. B. W. NELSON</i> Address <i>Berlin MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.5 Prematurity L. 18" W. 4 1/2 lbs.</i> DUE TO (b) <i>Central Edema + Multiple Petechial Hemorrhages</i> DUE TO (c) <i>massive Pulmonary Atelectasis</i> 20 hrs.		INTERVAL BETWEEN ONSET AND DEATH <i>2</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan 2</i> , 1959, to <i>Feb 2</i> , 1959, that I last saw the deceased alive on <i>Feb 2</i> , 1959, and that death occurred at <i>6:45</i> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Herman A. Robbins</i> M.D.		ADDRESS (Street, city or town, state) <i>Berlin, Md</i>	
PHYSICIAN'S NAME (Type) <i>Herman A. Robbins MD</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>2/4/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>EVERGREEN</i>	22d. LOCATION (City, town, or county) (State) <i>BERLIN MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Anna H. Surbaye</i>		ADDRESS <i>Berlin Md</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 9 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hirsch</i>	

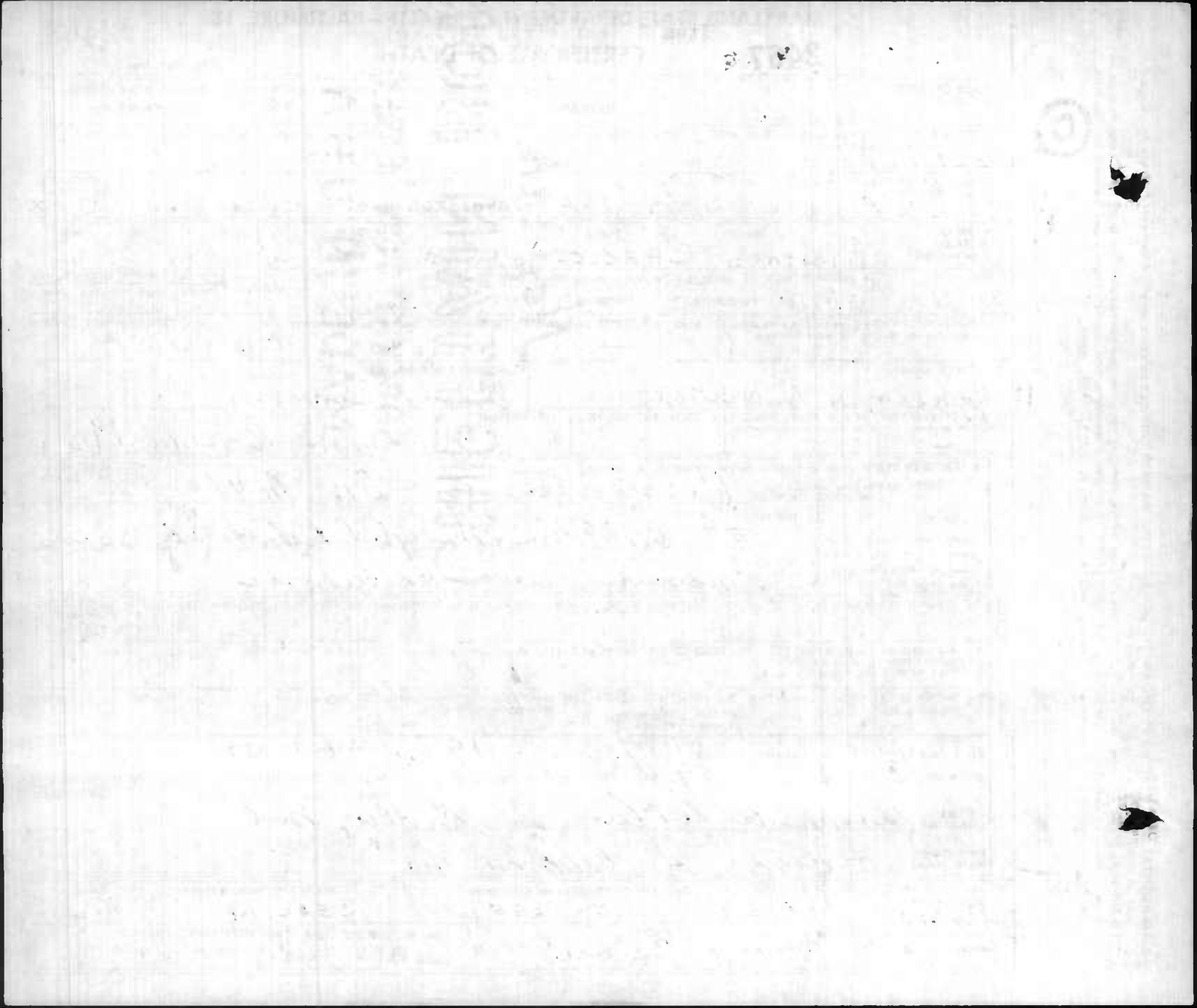
1

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2468

CERTIFICATE OF DEATH

Reg. Dist. No.

02464

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WORCESTER			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 38 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL				d. STREET ADDRESS 301 CLARK AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last ISAAC W. PEACOCK				4. DATE OF DEATH Month Day Year FEBRUARY 28 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 19, 1881	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OLIVER W. PEACOCK				14. MOTHER'S MAIDEN NAME MARTHA ROSS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —		INFORMANT Address WILLIAM E. PEACOCK, Pocomoke City, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach & Abdominal Intestines 151X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:17 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE William H. Folsom M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Salisbury Md. 2-28-59			
PHYSICIAN'S NAME (Type) Henry H. Watson							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-2-59		22c. NAME OF CEMETERY OR CREMATORY SALEM METHODIST		22d. LOCATION (City, town, or county) (State) Pocomoke City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Henry H. Watson				24a. REC'D BY REGISTRAR MAR 4 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

CERTIFICATE OF DEATH

1900

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SIGNATURE OF DECEASED

SIGNATURE OF WITNESSES

SIGNATURE OF MINISTER OF THE GOSPEL

SIGNATURE OF REGISTRAR

SIGNATURE OF CLERK

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CERTIFICATE OF DEATH

Reg. Dist. No.

02465

2469

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 113 Walston Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LILLIAN Middle GERTRUDE Last PERRY		4. DATE OF DEATH Month FEB. Day 27th Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1900
9. AGE (In years lost birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58 Days 58 Hours 58 Min.	11. IF UNDER 24 HRS. Months 58 Days 58 Hours 58 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Berlin, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Norris Holloway		14. MOTHER'S MAIDEN NAME Dora Ennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. E. Wilson Perry (Husband) 113 Walston Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombia 725x DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Cardiac Failure (c) Arteriosclerosis, Bedridden 30 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1, 1958 to 2-27, 1959 , that I last saw the deceased alive on 2-27, 1959 , and that death occurred at 1:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE WCB Smith		ADDRESS (Street, city or town, state) Medical Center, Salisbury, Maryland	
PHYSICIAN'S NAME (Type) Dr. William B. Smith		DATE SIGNED Feb. 27, 1959	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 1, 1959	
22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAR 3 '59		24b. REGISTRAR'S SIGNATURE William L. Haines	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02466

2470

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hebron</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>LEE</u> Last <u>Phillips</u>			4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1959</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 8, 1902</u>	9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u> Hours <u>3</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Wicomico Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>
13. FATHER'S NAME <u>Zackariah Travers</u>			14. MOTHER'S MAIDEN NAME <u>Nora Virginia White</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT Mr Samuel J. Phillips (Husband) Bradley St. Hebron Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery Disease</u> (c) <u>Diabetes Mellitus</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>February 7, 1959</u> to <u>Feb. 11, 1959</u> , that I last saw the deceased alive on <u>February 11, 1959</u> , and that death occurred at <u>10:29</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Feb. 11, 1959</u>					
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.					
PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr</u>		<u>Pine Bluff Rd. Salisbury Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 13, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hebron Maryland Cemetery - Hebron Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		
		DATE <u>FEB 13 '59</u>			

1. The purpose of this statement is to define the scope of work for the project.

2. The project is to develop a new software application for the company.

3. The project will be completed by the end of the year.

4. The project will be managed by the project manager.

5. The project will be funded by the company.

6. The project will be subject to the company's policies and procedures.

7. The project will be subject to the company's risk management process.

8. The project will be subject to the company's quality management process.

9. The project will be subject to the company's change management process.

10. The project will be subject to the company's communication management process.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

02467

Reg. Dist. No.

2471

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		TOWN		TOWN	
TOWN <u>Salisbury</u>				STREET ADDRESS (If rural give location)		STREET ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Peninsula Gen. Hosp.</u>				13 C Pineway			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>James Verlin Phoebus</u>				<u>Feb. 2 19 59</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>		<u>Nov. 6, 1958</u>	Yrs. <u>2</u>	Months <u>26</u>	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
				<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James B. Phoebus</u>				<u>Joyce Lovett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>James B. Phoebus Pineway Salisbury, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>500 X</u> IMMEDIATE CAUSE (A) <u>Acute purulent tracheobronchitis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>with early Bronchopneumonia</u>				<u>3 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>none</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 1, 19 59</u>, to <u>Feb 2, 19 59</u>, that I last saw the deceased alive on <u>Feb 1, 19 59</u>, and that death occurred at <u>6:50 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William Anderson</u>				ADDRESS (Street, city, town, state) <u>702 Camden Ave Salisbury Md</u>			
M.D. <u>7/3/59</u>				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>2-4-59</u>		<u>Siloam Cemetery</u>		<u>Siloam, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
		<u>Arthur S. Kraus</u>		<u>Thomas F. Wallace</u>			
DATE <u>FEB 5 '59</u>				ADDRESS <u>Salisbury</u>			

2082157XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G239 3-4-59 et

2472

CERTIFICATE OF DEATH

02468

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 36 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stevensville 17X-2	
f. STREET ADDRESS Walker Avenue / Home		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rosalie Middle Perry Last Price		4. DATE OF DEATH Month Feb. Day 26 Year 19 59	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/21/1870
9. AGE (In years last birthday) yrs. 88		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Willis Perry		14. MOTHER'S MAIDEN NAME Emma Mackey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. No	
17. INFORMANT Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 21 , 19 59 , to Feb. 26 , 19 59 , that I last saw the deceased alive on Feb. 26 , 19 59 , and that death occurred at 7:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 2/26/59 ACTUAL SIGNATURE L. V. Maldve M.D. PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF FEB. 28	22c. NAME OF CEMETERY OR CREMATORY CENTREVILLE	22d. LOCATION (City, town, or county) (State) CENTREVILLE MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar D. Kane		24. REC'D BY REGISTRAR DATE MAR 2 '59	24b. REGISTRAR'S SIGNATURE Catharine S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE

REGISTRATION NO.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. PLACE OF DEATH		9. DATE OF DEATH		10. TIME OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. PLACE OF INTERMENT		14. DATE OF INTERMENT		15. TIME OF INTERMENT	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF DECEASED		18. SIGNATURE OF WITNESSES		19. SIGNATURE OF PHYSICIAN		20. SIGNATURE OF CLERGYMAN	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF SHERIFF		23. SIGNATURE OF CLERK		24. SIGNATURE OF NOTARY		25. SIGNATURE OF OTHER OFFICIALS	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2473 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02469

Item 1 Film G239 2-20-59 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>At home</u>		e. STREET ADDRESS <u>601 West Over Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Cheryl</u> Middle <u>A</u> Last <u>Purnell</u>		4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 31, 1958</u>
9. AGE (In years last birthday) <u>3</u> yrs		10. IF UNDER 1 YEAR Months <u>3</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u></u>		14. MOTHER'S MAIDEN NAME <u>Annie Purnell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Hillie Kernell</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVE (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-13-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Hills</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Blair McClush</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

2082213XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
OFFICE OF THE STATE MEDICAL EXAMINER
CERTIFICATE OF DEATH

NOT STATE
HEALTH OFF

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of medical examiner	
9. Signature of attending physician		10. Signature of coroner		11. Signature of registrar		12. Signature of funeral director	
13. Signature of physician		14. Signature of physician		15. Signature of physician		16. Signature of physician	
17. Signature of physician		18. Signature of physician		19. Signature of physician		20. Signature of physician	
21. Signature of physician		22. Signature of physician		23. Signature of physician		24. Signature of physician	
25. Signature of physician		26. Signature of physician		27. Signature of physician		28. Signature of physician	
29. Signature of physician		30. Signature of physician		31. Signature of physician		32. Signature of physician	
33. Signature of physician		34. Signature of physician		35. Signature of physician		36. Signature of physician	
37. Signature of physician		38. Signature of physician		39. Signature of physician		40. Signature of physician	
41. Signature of physician		42. Signature of physician		43. Signature of physician		44. Signature of physician	
45. Signature of physician		46. Signature of physician		47. Signature of physician		48. Signature of physician	
49. Signature of physician		50. Signature of physician		51. Signature of physician		52. Signature of physician	
53. Signature of physician		54. Signature of physician		55. Signature of physician		56. Signature of physician	
57. Signature of physician		58. Signature of physician		59. Signature of physician		60. Signature of physician	
61. Signature of physician		62. Signature of physician		63. Signature of physician		64. Signature of physician	
65. Signature of physician		66. Signature of physician		67. Signature of physician		68. Signature of physician	
69. Signature of physician		70. Signature of physician		71. Signature of physician		72. Signature of physician	
73. Signature of physician		74. Signature of physician		75. Signature of physician		76. Signature of physician	
77. Signature of physician		78. Signature of physician		79. Signature of physician		80. Signature of physician	
81. Signature of physician		82. Signature of physician		83. Signature of physician		84. Signature of physician	
85. Signature of physician		86. Signature of physician		87. Signature of physician		88. Signature of physician	
89. Signature of physician		90. Signature of physician		91. Signature of physician		92. Signature of physician	
93. Signature of physician		94. Signature of physician		95. Signature of physician		96. Signature of physician	
97. Signature of physician		98. Signature of physician		99. Signature of physician		100. Signature of physician	



2474

CERTIFICATE OF DEATH

Reg. Dist. No.

02470

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Va.</u> b. COUNTY <u>Accomack</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>83X-3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Laura E</u> Middle <u>SHARPLEY</u> Last <u>SHARPLEY</u>				4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>11</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 20, 1898</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>61</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		11. BIRTHPLACE (State or foreign country) <u>Chesapeake</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Chesapeake</u>			
13. FATHER'S NAME <u>Joseph L. Steffens</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Reid</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Utho P Sharpley</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> (c) <u>Essential Hypertension</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chesapeake</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-11-</u> , 19 <u>59</u> , to <u>2-11-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>11:25</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u>				DATE SIGNED <u>2/12/59</u>			
PHYSICIAN'S NAME (Type) <u>Salisbury Md</u>				M.D. <u>Salisbury Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-14-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenbarkville</u>		22d. LOCATION (City, town, or county) (State) <u>Greenbarkville Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs W A. Shields</u>				ADDRESS <u>New Church, Va</u>			
24a. REC'D BY REGISTRAR <u>FEB 18 '59</u>				24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

Death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02471

2475

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHRISTIAN CLEVELAND Shelton</u>		4. DATE OF DEATH <u>February 7 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5 1901</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resturant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>David R. Shelton</u>	
14. MOTHER'S MAIDEN NAME <u>Lillie Belle Christian</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Informant</u>		17. ADDRESS <u>Mrs. C.C. Shelton, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO (b) <u>Arteriosclerotic Coronary Artery Disease</u> DUE TO (c) <u>Arteriosclerotic Coronary Artery Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>February 1, 1959</u> , to <u>Feb 7, 1959</u> , that I last saw the deceased alive on <u>Feb 7, 1959</u> , and that death occurred at <u>10:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>2/7/59</u>	
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill Jr. Pine Buff Rd., Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	22b. DATE THEREOF <u>2/10/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Md.</u>		24. RECEIVED BY REGISTRAR <u>Feb 10 59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Norman T. Baker</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2476

CERTIFICATE OF DEATH

Reg. Dist. No.

02472

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>30 yr</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Shockley</u> Last <u>Shockley</u>				4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-9-09</u>	
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min.		IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Libor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Smobell md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>?</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>214-28-354</u>			
17. INFORMANT <u>Katie Bartley - Salisbury md</u>				Address <u>Salisbury md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Subarachnoid hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>1 month</u> (c) <u>1 month</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>17 Jan</u> , 19 <u>59</u> to <u>17 Feb</u> , 19 <u>59</u> that I last saw the deceased alive on <u>17 Feb</u> , 19 <u>59</u> and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Purnell</u> M.D.				ADDRESS (Street, city or town, state) <u>20 Feb 59</u>			
PHYSICIAN'S NAME (Type) <u>Purnell</u>				DATE SIGNED <u>20 Feb 59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>2-21-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Cem</u>	
22d. LOCATION (City, town, or county) (State) <u>md</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Brookland H. West</u> ADDRESS <u>Salisbury md</u>				24a. REC'D BY REGISTRAR <u>Feb 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

RECEIVED

8016



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TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or funeral home.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2477

CERTIFICATE OF DEATH

Reg. Dist. No.

02473

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>Route 1</u>	
3. NAME OF DECEASED (Type or print) <u>Maggie Ellen</u> First Middle Last		4. DATE OF DEATH <u>FEBRUARY 4</u> 19 <u>59</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 19, 1911</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labour & Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Bishop, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Fasset</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Herbert Shockley - Ocean City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260x Uremia</u> DUE TO (b) <u>Intercaillary Glomerulosclerosis</u> DUE TO (c) <u>Diabetes Mellitus</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERCAILLARY</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-4</u> , 19 <u>59</u> , to <u>5:08 PM</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2-4</u> , 19 <u>59</u> , and that death occurred at <u>5:08 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>2-4-59</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/8/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sarah Dukes</u>		22d. LOCATION (City, town, or county) (State) <u>Bishop Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry N. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 9 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

THE STATE OF TEXAS, County of DALLAS, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of DALLAS, State of TEXAS, this 1st day of January, 1911.

Attest my hand and the seal of said County, this 1st day of January, 1911.

County Clerk

2478

CERTIFICATE OF DEATH

Reg. Dist. No.

02474

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i> COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN 1b <i>X Eden</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>82 PENINSULA GENERAL HOSPITAL</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>John</i> Middle <i>W</i> Last <i>SMITH</i>		4. DATE OF DEATH Month <i>FEBRUARY</i> Day <i>14</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 31, 1889</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	
11. BIRTHPLACE (State or foreign country) <i>Eden, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Fairfax Smith</i>		14. MOTHER'S MAIDEN NAME <i>Mary Riggin Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>John Riggin Smith (Son)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>446 X</i> DUE TO <i>Chronic Nephrosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cerebral Arteriosclerosis, Prostatic Hypertrophy</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>1:54</i> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>David J. Gilman</i>		DATE SIGNED <i>2/14/59</i>	
PHYSICIAN'S NAME (Type) <i>David J. Gilman</i>		ADDRESS (Street, city or town, state) <i>Salisbury Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/17/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Family Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Near Eden Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lewen R. Wilson, Princess Anne</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 18 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanks</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

IN SENATE, January 1, 1918.

REPORT OF THE

COMMISSIONER OF THE GENERAL LAND OFFICE

FOR THE YEAR 1917

AND

STATE OF THE LAND OFFICE

FOR THE YEAR 1917

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STATE OF THE LAND OFFICE

FOR THE YEAR 1917

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2492
CERTIFICATE OF DEATH

Reg. Dist. No.

02475

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 Ocean City Road		d. STREET ADDRESS R.D.# 3 Ocean City Blvd	
3. NAME OF DECEASED (Type or print) LOIS ELIZABETH SMITH		4. DATE OF DEATH Month FEBRUARY Day 3rd Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1935
9. AGE (In years last birthday) 23 yrs.		IF UNDER 1 YEAR Months 2 Days 17	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Teaching	11. BIRTHPLACE (State or foreign country) Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME William M. Smith	
14. MOTHER'S MAIDEN NAME Blanche Avery Williams		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. Mr. William M. Smith (Father)		17. INFORMANT R.D.# 3 Ocean City Blvd. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Vaccinomatosis 196.9 DUE TO Ewing's Sarcoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 1 mos. 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 4 , 19 59 , to FEB 2 , 19 59 , that I last saw the deceased alive on Feb. 2 , 19 59 , and that death occurred at 5:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Maryland Ave. Salisbury, Maryland DATE SIGNED Feb. 4, 1959 ACTUAL SIGNATURE Earl M. Beardsley M.D. PHYSICIAN'S NAME (Type) Dr. Earl M. Beardsley			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 6, 1959	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR FEB 5 '59
		24b. REGISTRAR'S SIGNATURE Arthur L. Frank	

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VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2000

DATE OF DEATH

2000

PLACE OF DEATH

AT HOME

DATE OF BIRTH

2000

PLACE OF BIRTH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2479

CERTIFICATE OF DEATH

02476 ✓

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				d. STREET ADDRESS 404 Race St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NETTIE Middle MAY Last SMULLEN				4. DATE OF DEATH Month FEB. Day 6th Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1905		9. AGE (In years Day birthday) yrs. 53	IF UNDER 1 YEAR Months 11 Days 28	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) R.D.# 5 Salisbury, Md		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Emory Burton Arvey				14. MOTHER'S MAIDEN NAME Martha Hannah Parker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. INFORMANT		Address Mr. Fredrick Smullen (Husband) 404 Race St Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 482X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocardial insufficiency DUE TO (c) Acute Influenza of Enteritis							INTERVAL BETWEEN ONSET AND DEATH 12 hrs 2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 2-5, 1959 , to 2-6, 1959 that I last saw the deceased alive on 2/6, 1959 , and that death occurred at 10:25 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Medical Center, Salisbury, Maryland			
ACTUAL SIGNATURE W. B. Smith		M.D. Medical Center, Salisbury, Maryland		DATE SIGNED Feb. 6, 1959			
PHYSICIAN'S NAME (Type) Dr. William B. Smith		Medical Center- Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Smullen Cemetery	22d. LOCATION (City, town, or county) (State) Worcester Co. Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND		24. REG'D. BY REGISTRAR FEB 7 1959	24b. REGISTRAR'S SIGNATURE Arthur L. Hines		

2878

UNITED STATES OF AMERICA

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2480 CERTIFICATE OF DEATH

02477

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Wicomico</u>		STATE <u>Maryland</u>		COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Salisbury</u>		LENGTH OF STAY (in this place) <u>Since 4/29/58</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crisfield</u>		<u>19X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Pine Bluff State Hospital Salisbury, Maryland</u>				STREET ADDRESS (If rural give location) <u>RFD #1</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Robert William Sterling</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 9 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 15, 1893</u>		9. AGE last birthday <u>65</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Crisfield, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John H. Sterling</u>				14. MOTHER'S MAIDEN NAME <u>Esther Webster</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-05-0107</u>		17. INFORMANT & ADDRESS (Hospital) <u>Patient when adm. to Hosp. Records)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
002X IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>16 years</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>April 29, 1958</u> , to <u>Feb. 9, 1959</u> , that I last saw the deceased alive on <u>Feb. 7, 1959</u> , and that death occurred at <u>8:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward P. Ritchie</u> M.D.				ADDRESS (Street, city, town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>2/9/59</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>FEB 11-1959</u>		NAME OF CEMETERY OR CREMATORY <u>ASBURY METHODIST</u>		LOCATION (City, town, or county) (State) <u>CRISFIELD MD</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 13 '59</u>		REGISTRAR'S SIGNATURE <u>Arthur E. Kears</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>L. B. Webster Crisfield Md</u>			

1980 CERTIFICATE OF DEATH

Page 1 of 2

1. DEATH OF DECEASED

2. PLACE OF DEATH

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF BIRTH: [illegible]
 PLACE OF BIRTH: [illegible]
 MARRIAGE: [illegible]
 OCCUPATION: [illegible]
 SOCIAL SECURITY NUMBER: [illegible]
 MARITAL STATUS: [illegible]
 RACE: [illegible]
 ETHNIC ORIGIN: [illegible]
 RELIGION: [illegible]
 EDUCATION: [illegible]
 MOTHER'S MARRIAGE: [illegible]
 FATHER'S MARRIAGE: [illegible]
 DECEASED'S MARRIAGE: [illegible]

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. SIGNATURE OF DECEASED

8. SIGNATURE OF WITNESSES

9. SIGNATURE OF DECEASED'S PHYSICIAN

10. SIGNATURE OF DECEASED'S SURGEON

11. SIGNATURE OF DECEASED'S DENTIST

12. SIGNATURE OF DECEASED'S NURSE

13. SIGNATURE OF DECEASED'S CHAPLAIN

14. SIGNATURE OF DECEASED'S MINISTER

15. SIGNATURE OF DECEASED'S RABBI

16. SIGNATURE OF DECEASED'S PRIEST

17. SIGNATURE OF DECEASED'S BISHOP

18. SIGNATURE OF DECEASED'S ARCHBISHOP

19. SIGNATURE OF DECEASED'S CARDINAL

20. SIGNATURE OF DECEASED'S POPE

21. SIGNATURE OF DECEASED'S BISHOP

22. SIGNATURE OF DECEASED'S ARCHBISHOP

23. SIGNATURE OF DECEASED'S CARDINAL

24. SIGNATURE OF DECEASED'S POPE

25. SIGNATURE OF DECEASED'S BISHOP

26. SIGNATURE OF DECEASED'S ARCHBISHOP

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02478

2493

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Poplar St. APT #2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis Thompson</u>		4. DATE OF DEATH <u>2-22-59</u> 19 <u>59</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-58</u>
9. AGE (in years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR <u>2</u> Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Waters</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lucy Waters, Poplar St. Fruitland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>525X</u> IMMEDIATE CAUSE (a) <u>Interstitial pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>interstitial pneumonia</u> (c) <u>interstitial pneumonia</u> DUE TO underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>interstitial pneumonia</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Flower Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eden Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.F. Stewart</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Hume</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		DATE <u>MAR 2 '59</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, date of death, and cause of death. The form is partially filled out with handwritten text.

NAME: JOHN J. BROWN
AGE: 45 SEX: M
DATE OF DEATH: 10/12/1912
PLACE OF DEATH: 123 Main St, Boston
CAUSE OF DEATH: Myocardial Infarction
MANNER OF DEATH: Natural

11/21/1912
J. J. Brown

2481

CERTIFICATE OF DEATH

02479

Reg. Dist. No.

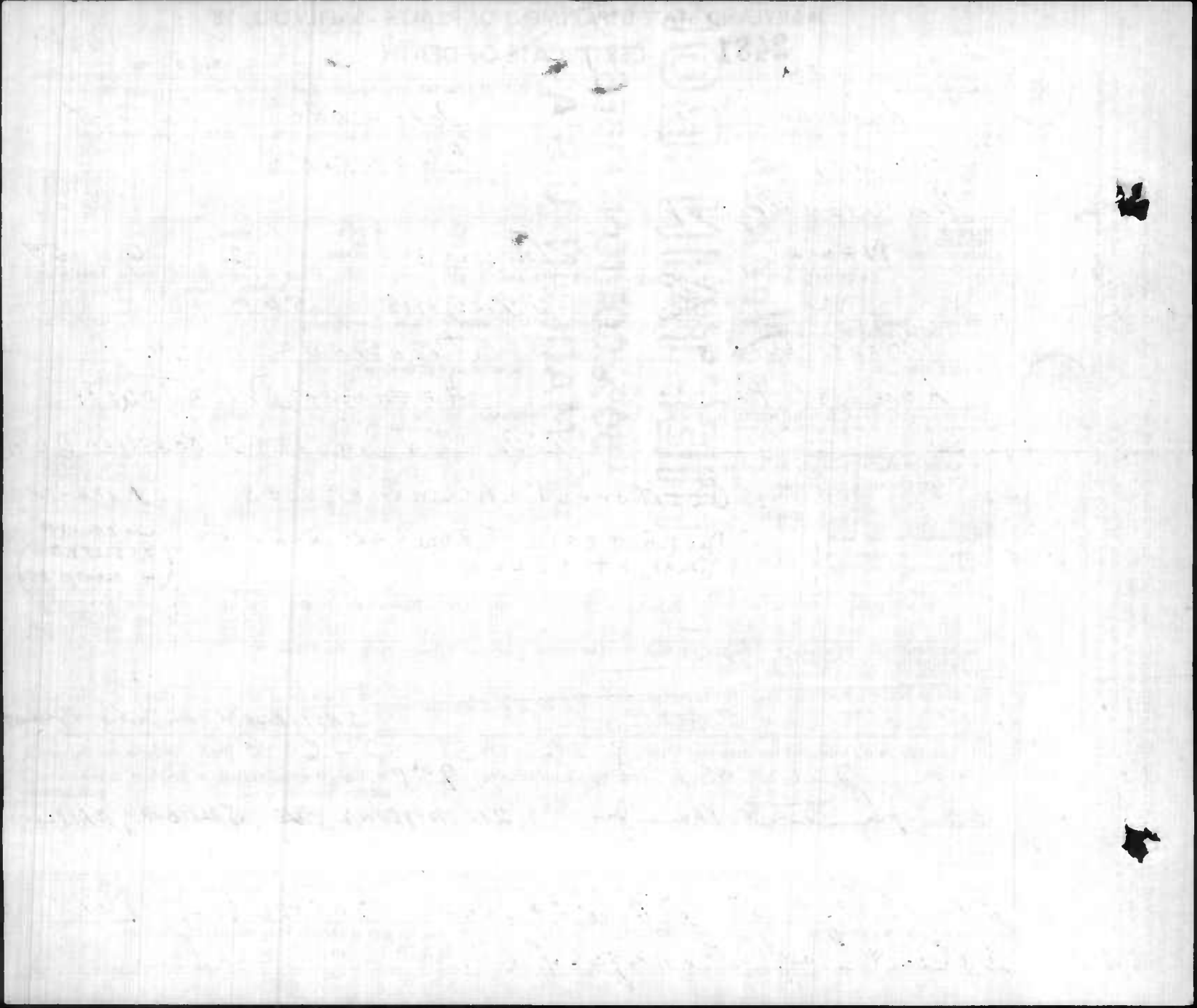
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD R.D.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>46x-3</u>	
3. NAME OF DECEASED (Type or print) <u>Naomi</u> First Middle Last <u>Townsend</u>		4. DATE OF DEATH Month <u>2</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 5, 1908</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Leuel Palmer</u>	
14. MOTHER'S MAIDEN NAME <u>UNKNOWN DELLA TRUITT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u></u>	
16. SOCIAL SECURITY NO. <u></u>		INFORMANT Address <u>MR. CLAYTON TOWNSEND FRANKFORD, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.0 Peritoneal CARCINOMATOSIS</u> DUE TO (b) <u>METASTATIC FROM CARCINOMA OF</u> RIGHT COLON Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 MONTH</u> <u>UNKNOWN (RESECTED)</u> <u>4 MONTHS AGO</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u></u> p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) <u>SALISBURY</u> (County) <u>Wicomico</u> (State) <u>MARYLAND</u>
21. I certify that I attended the deceased from <u>1-6</u> , 19 <u>59</u> to <u>2-6</u> , 19 <u>59</u> that I last saw the deceased alive on <u>2-6</u> , 19 <u>59</u> , and that death occurred at <u>8:55 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harold R. Man Jr.</u>		ADDRESS (Street, city or town, state) <u>210 MARYLAND AVE, SALISBURY, MARYLAND</u>	
PHYSICIAN'S NAME (Type) <u></u>		DATE SIGNED <u></u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-9-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. GEORGE'S Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>CLARKSVILLE, Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u>		ADDRESS <u>Frankford, Del.</u>	
24a. REC'D BY REGISTRAR <u>FEB 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02480

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 Wk.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS Pittsville	
3. NAME OF DECEASED (Type or print) First Middle Last HARRY CLEVELAND TRUITT			4. DATE OF DEATH Month Day Year 2 4 1959		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/1884		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Buyer			10b. KIND OF BUSINESS OR INDUSTRY Fruits.		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Greensbury Truitt			14. MOTHER'S MAIDEN NAME Hannah M. White		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 217-05-2544		17. INFORMANT Address Mr. Billy H. Truitt, Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural + Subarachnoid hemorrhage 816X DUE TO Fracture of Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture of Skull DUE TO (c) Fracture of Skull PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of Skull INTERVAL BETWEEN ONSET AND DEATH Days Days					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Collision of car fell out of car's structural head			
20c. TIME OF INJURY Month, Day, Year 8:45 a.m. 1-28 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At 50		20f. (City or town) (County) (State) Pittsville Wicomico Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Earl L. Royer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-5-59	
EXAMINER'S NAME (Type) Earl L. Royer		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/6/59		22c. NAME OF CEMETERY OR CREMATORY Line Church Cemetery	
22d. LOCATION (City, town, or county) (State) Whiteville, Del.					
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Md.			ADDRESS Norman D. Baker		24a. REC'D BY REGISTRAR DATE FEB 10 1959
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2483

Item 7 Film G239 2-24-59 et

CERTIFICATE OF DEATH

12481

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deal Island</u> 19X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Deliah</u> Middle <u>E</u> Last <u>Wallace</u>		4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1896</u>
9. AGE (In years last birthday) <u>62</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Taskin</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>George Wallace - Rehoboth Beach, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u> 434.1 DUE TO <u>Rt. Side Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>14 Feb 1959</u> to <u>18 Feb 1959</u> that I last saw the deceased alive on <u>15 Feb 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>15 Feb 59</u>			
ACTUAL SIGNATURE <u>E. A. Lunnell</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<u>Burial</u>		<u>Feb. 18, 1959</u>	
22c. NAME OF CEMETERY <u>John Wesley</u>		22d. LOCATION (City, town, or county) (State) <u>Deal Island, Som. Co, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. Ward, Marion Station, Md. #235</u> ADDRESS		24a. REG'D BY REGISTRAR <u>FEB 19 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE	

2483

ADUW

Charles H. West
John West

2484

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> 23x-2 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>B. Henry Waters</u>		4. DATE OF DEATH Month Day Year <u>February 18 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Mar 22 - 1899</u>
9. AGE (In years last birthday) <u>59 1/2</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hammill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Snow Hill, Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John Waters</u>		14. MOTHER'S MAIDEN NAME <u>Mary Sturgis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or uncertain) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs Cecilia Blake Snow Hill Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chalcopyctony</u> DUE TO (c) <u>Cerebrosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1:30</u> , 19 <u>59</u> , to <u>2:18</u> , 19 <u>59</u> that I last saw the deceased alive on <u>2:18</u> , 19 <u>59</u> , and that death occurred at <u>3:00</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. H. Briele</u>		ADDRESS (Street, city or town, state) <u>Medical Center</u> DATE SIGNED <u>2-19-59</u>	
PHYSICIAN'S NAME (Type) <u>H. H. Briele</u>		<u>Salisbury, Md</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Buried Feb 21/59</u>		22b. DATE THEREOF	
23. FUNERAL DIRECTOR'S SIGNATURE <u>May B. Ginnis</u>		23b. NAME OF CEMETERY OR CREMATORY <u>Not Wisely Cemetery</u>	
ADDRESS <u>Snow Hill, Md</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill Md</u>	
24. REC'D BY REGISTRAR <u>FEB 24 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Page 4

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A15 (4)
15M 9/58

[Faint, illegible text, likely bleed-through from the reverse side of the page]



2494

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <u>17</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Stephen H Water</u>		4. DATE OF DEATH Month <u>2</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>C.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Eden md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Stephen H Water</u>		14. MOTHER'S MAIDEN NAME <u>Rhodia Simmons</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sarah Water</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension essential</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> to <u>2-26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>19</u> and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>L.V. Sohler</u>		ADDRESS (Street, city or town, state) <u>303 East Street, Schuerman Md</u> DATE SIGNED <u>3-28-59</u>	
PHYSICIAN'S NAME (Type) <u>L.V. Sohler</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-3-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barbara M West</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Froude</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

FILE NO.

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE CLERK OF THE COUNTY OF NEW YORK, IN THE CITY OF NEW YORK, IN THE YEAR 1900.

1900

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2485

CERTIFICATE OF DEATH

Reg. Dist. No.

02484

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3Yr.9Mos.20Da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sam</u> Middle <u>Whiteley</u> Last <u>Whiteley</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>February 11, 1879</u>		9. AGE (In years last birthday) <u>80</u> yrs.	10. IF UNDER 1 YEAR Months <u>14</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Whiteley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Mitchell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>218-20-7254</u>		17. INFORMANT <u>Hospital Records - Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, General</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Year</u> <u>Years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/25/59</u> , 19 <u>59</u> , to <u>2/14/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2/14/59</u> , 19 <u>59</u> , and that death occurred at <u>4:20A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>L. Maldve</u>				ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u>		DATE SIGNED <u>2/14/59</u>	
PHYSICIAN'S NAME (Type) <u>L. Maldve, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Feb. 16 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wye Church</u>		22d. LOCATION (City, town, or county) (State) <u>6 Sep Mills, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. E. Newman & Son</u>				ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 1959</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2558

MASSACHUSETTS
TOWN OF BOSTON

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES B. BROWN		M		45		JAN 15 1880		BOSTON, MASS.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
123 MAIN ST.		Carpenter		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH		SECOND OF DEATH	
JAN 20 1925		10:30 AM		10		30		00	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		TIME OF SIGNATURE		HOUR OF SIGNATURE		MINUTE OF SIGNATURE		SECOND OF SIGNATURE	
JAN 20 1925		11:00 AM		11		00		00	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2486

CERTIFICATE OF DEATH

Reg. Dist. No.

02485

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 1729 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 1 924 N. Division Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lawrence Middle Wright Last Wright				4. DATE OF DEATH Month February Day 12 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/8/1872	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.		11. BIRTHPLACE (State or foreign country) Maryland, Queen Anne's Co.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Farmer			
13. FATHER'S NAME Stephen Wright				14. MOTHER'S MAIDEN NAME Laura Virginia Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Polyp of bladder, low grade malignancy 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from May 20 19 54 , to Feb. 12 19 59 , that I last saw the deceased alive on Feb. 12 19 59 , and that death occurred at 7:15AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 2/12/59 ACTUAL SIGNATURE G. Kosmahly M.D. PHYSICIAN'S NAME (Type) G. Kosmahly, M. D. Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 14-59		22c. NAME OF CEMETERY OR CREMATORY Chestnutfield		22d. LOCATION (City, town, or county) (State) Centerville Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Lawrence Burt				ADDRESS Centerville Maryland		24a. REC'D BY REGISTRAR DATE FEB 16 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

CERTIFICATE OF DEATH

2538

See the form

PLACE IN SPACE		NATURAL		CAUSE OF DEATH	
1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. TIME OF DEATH		9. SIGNATURE OF PHYSICIAN	
10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF WITNESS		12. SIGNATURE OF DECEASED	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF DECEASED		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
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100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	

MASSACHUSETTS DEPARTMENT OF HEALTH - BIRTH AND DEATH RECORDS